PATIENT DEMOGRAPHIC SHEET

Date: _____

PATIENT INFORMATION

Patient Full Name:
_____
Patient's SSN: _____-_____-_____ Date of Birth: _____ SEX: M _____ F _____
Street Address: _____Apt. No.: _____
City: _____ State _____ Zip Code: _____
Home phone: (_____) _____Work phone: (_____) _____ Cell/Mobile number: (_____) _____ Email Address: _____ Employer:
_____

Emergency Contact Name: _____
Contact Phone: (_____) _____
Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance Company's Name:
_____
Insurance Address:
_____
City: _____ State _____ Zip Code: _____ Policy Holder's Social Security Number: _____ - ____ - _____
Name of Policy Holder:
_____
Policy Holder's Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

***We do not bill any secondary insurance. We can provide you with all the necessary documentation to be submitted by you.**

I CERTIFY THAT I AND/OR MY DEPENDENTS HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO MISSOULA ENDODONTICS, PC, ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO

ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DENTIST MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING THE INSURANCE BENEFIT OF THE BENEFITS PAYABLE SERVICES.

Signature: _____ Date: _____